

# American Optometric Association NEWS



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No. 2



**Leonard Press, O.D., left, and Bill Nye the Science Guy wave to reporters after one of more than 31 interviews conducted via phone and satellite Aug. 2.**

## AOA, VSP campaign to prevent Computer Vision Syndrome as school begins

Bill Nye the Science Guy and Leonard Press, O.D., appeared live on 12 TV stations and five radio stations, as part of a satellite media tour covering 31 interviews, Aug. 2. The "tour" included four national outlets.

They used the opportunity to discuss the importance of eye examinations before school begins and to urge parents to visit [mychildsvision.com](http://mychildsvision.com).

The site, jointly hosted by the AOA and Vision Service Plan (VSP), includes tools such as information on

See Campaign, page 14

## Researchers urge increased funding for children's vision studies

A series of federally funded studies is producing breakthroughs in the diagnosis and treatment of children's vision problems, researchers reported during a recent congressional briefing.

However, those studies could now be threatened unless adequate funding is maintained, the researchers warned. That assessment came during the Alliance for Eye and Vision Research's (AEVR) Children's Vision Research briefing, June 28 on Capitol Hill.

The AOA is a member of the alliance and a leading proponent of federal eye research funding. AEVR Executive Director James Jorkasky noted that a doubling of the National Institutes of Health (NIH) budget, over federal fiscal years 1998 through 2003, enabled the National Eye Institute (NEI) to significantly expand children's vision research.

However, "with flat-to-negative funding since the doubling ended, the renewal of these studies could be jeopardized," said Jorkasky.

The NEI children's vision research projects are large-population studies designed to

characterize the prevalence of various conditions and determine the best treatments. As such, they provide for "a rapid translation of basic research into clinical practice, thereby maximizing patient benefit," Jorkasky noted.

Lynn Cyert, O.D., told lawmakers that the NEI's multi-center Vision in Preschoolers (VIP) Study is providing valuable insight on the accuracy of vision screening tests. Dr. Cyert is a principal investigator for the study.

The NEI's Pediatric Eye Disease Investigator Group (PEDIG) has reported on recent breakthroughs resulting from the collaborative network's research on strabismus, amblyopia and other eye disorders that affect children. The group has also recently released NEI research on treatment of retinopathy of prematurity.

Dr. Cyert emphasized that much of the ongoing federally funded research offers potential to improve care for the children of minority populations. She is chief of pediatric and infant vision services at Northeastern State University College of



**Lynn Cyert, O.D., with Rep. Gene Green (D-TX), co-chair of the Congressional Vision Caucus.**

Optometry in Tahlequah, OK, and works with the Cherokee Nation Head Start.

The NEI is also funding the Multi-Ethnic Pediatric Eye Disease Study (MEPEDS) and Baltimore Pediatric Eye Disease Study (BPEDS), which also centers in multi-ethnic populations.

In testimony before a congressional committee in March, the AOA called for a 6.7 percent increase in federal eye and vision research funding, recommending a fiscal year 2008 budget of \$31 billion for the NIH and \$711 million for the NEI.

The AOA has made NEI funding increases a legislative priority for this year.

### At a glance:



Patients now appear a bit more likely to purchase contact lenses from their eye care providers than in the recent past.



### Letters

FDA seeks help in replacing solutions, Optometrists and Public Health

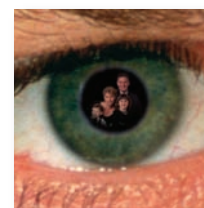
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**References:** 1. Contact Lens Research Services. Andrasko corneal staining grid. Available at: <http://www.staininggrid.com/grid.aspx>. Accessed April 24, 2007. 2. Andrasko GJ, Ryan KA, Garofalo RJ, et al. Compatibility of silicone hydrogel lenses with multi-purpose solutions. Alcon Laboratories, Inc. Poster presented at: ARVO; April 2006; Fort Lauderdale, Fla. 3. Data on file. Alcon Laboratories, Inc. 4. Meadows D, Ketelson H, David R, et al. The impact of water content and care regimen on the long term ex vivo clinical wettability of soft contact lenses. Poster presented at: AAO; Dec. 2005; San Diego, Calif. 5. Meadows DL, Ketelson HA, McQueen N, Stone R. Dynamic wetting behavior of pHEMA-MAA and silicone hydrogel contact lenses. Alcon Laboratories, Ft. Worth, Tex. ARVO Poster. 2004. 6. Survey of 305 Optometrists. Harris Interactive® December 2006.





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## PRESIDENT'S COLUMN

# Boelcke's Dicta

**E**arly in World War I, the use of airplanes was new to the business of warfare. It was not clear exactly how to employ these modern killing machines, nor were the tactics of attack well-developed.

The result of all this lack of knowledge was that many young flyers lost their lives, victim not to the enemy, but rather their own mistakes.

By 1916, Lieutenant Oswald Boelcke had not only survived the early years of aerial warfare, but had become Germany's first ace and was one of the first two pilots to receive the famous Blue Max. So skilled was Boelcke that the German High Command asked him to create a set of rules for fighter pilots that might assure not only enemy kills, but their safe return to home airfields. The rules he set forth became known as "Boelcke's Dicta" and survived for many years as the primary guide for fighter pilots.

In Boston, I challenged the AOA to continue our effort to "push the envelope" legislatively in Washington. To accomplish this goal will require much from each AOA member, staff person and AOA volunteer, and as I reflect on "Boelcke's Dicta," I suggest to you that they give us much insight into how to be successful legislatively.

**1. Try to secure advantages before attacking. If possible, keep the sun behind you.**

To be successful legislatively, we need to be organized,

focused and agile. You can be assured that your Washington Office staff, led by Jon Hymes, is always prepared. Access to legislators and potential sponsors is enhanced by a healthy political action committee, AOA-PAC, and I urge every member to contribute as much as you can to help support those legislators who support us. The AOA Keyperson program puts ODs on the frontlines when the AOA needs to move fast in contacting legislators or attracting sponsors for a bill. And, while we might not be able to attack from the sun, we must always remember that the fight is not over until the sun sets.

**2. Always carry through an attack when you have started it.**

Success in the legislative arena requires the collective will and the resources to carry a fight to the finish. Many of our successes in Washington may not appear promising at the start with many opponents and seemingly overwhelming odds. Only by the tenacious efforts of individual ODs who volunteer to serve as Keypersons, effective use of AOA-PAC resources, and the skill of the Washington Office team are we able to achieve legislative results that are good for optometry and good for our patients.

**3. Fire only at close range and only when your opponent is properly in your sights.**

Legislatively, we always try to narrow the focus of our legislative concern. This

makes communication with legislators and our members more efficient and understandable. This rule also implies that it is wise to be a good vote counter before you bring a bill to the floor of a legislative body—something the AOA knows how to do very well.

**4. Always keep your eye on your opponent, and never let yourself be deceived by ruses.**

We need to be alert to what our opponents are up to, lest we be caught unprepared. Our Advocacy Group volunteers, including the dedicated members of the AOA Professional Relations Committee, as well as our Washington office, do an incredible job of gathering information about what other professions, industries and the government are proposing that will have impact on your ability to serve your patients.

**5. In any form of attack it is essential to assail your opponent from behind.**

While it may not be practical to completely surprise our opponents with our legislative agenda, it is always our goal to have as much support lined up for our cause before the opposition has a chance to obtain commitments for its position. Whenever the opposition is unprepared or uncertain, we improve our chances for success.

**6. If your opponent dives on you, do not try to evade his onslaught, but fly to meet it.**

For the AOA, this means never avoiding an issue —



Dr. Alexander

especially the difficult ones. We must always be prepared for the unexpected and try to anticipate the questions and present logical, thoughtful responses. The volunteers serving on the AOA Federal Relations Committee monitors legislation introduced in Congress and acts as the profession's legislative "think tank."

**7. When over the enemy's lines never forget your own line of retreat.**

Rather than think in terms of retreat, to me, this rule means that the AOA must never forget the members and the patients we serve. As we get involved legislatively, we must never give in to expediency, but rather keep in mind that for patients to receive the best in eye care, the profession of optometry must be strong, viable and healthy.

**8. Attack on principle in groups of four or six. When the fight breaks up into a series of single combats, take care that several do not go for one opponent.**

The AOA must continue to develop legislative coalitions with organizations and professions that have similar concerns. The formal agree-

See President, page 6

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## SCHIP bills advance in both houses

The U.S. House and Senate both passed State Children's Health Insurance Program (SCHIP) bills in the first week of August. Included in the House bill is a Medicare fee fix that would eliminate a 9.9 percent planned cut in Medicare fees next year. The Senate bill does not address Medicare.

The AOA has been working with legislators to

ensure that eye and vision coverage continues to be a priority under SCHIP, which was created in 1997 and is due to expire in September.

SCHIP is jointly financed by the federal and state governments, but is administered by the states.

Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels

for coverage, and administrative and operating procedures.

Although eye and vision coverage under SCHIP is mandatory in only 10 states and the District of Columbia, every state includes eye and vision care in its coverage of SCHIP beneficiaries.

With Congress focusing on children's health, the AOA sought to advance children's vision funding legislation (the *Vision Care for Kids Act*, HR

507) without putting the issue at risk due to the politics of the extremely contentious SCHIP reauthorization process.

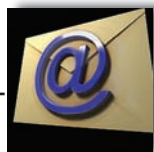
It is expected that the *Vision Care for Kids Act*, which was approved by the Energy and Commerce Subcommittee on Health on July 19, will be considered by the full committee in September.

In a largely party-line

225-204 vote, the House passed HR 3162, reauthorizing SCHIP and adding \$47.8 billion in additional funds to the program over the next five years. The Senate bill passed 68-31, a margin large enough to override a threatened presidential veto.

The Senate version of the bill (S. 1896) would provide \$35 billion for SCHIP over

See SCHIP, page 12



## LETTERS

### FDA seeks help in replacing solutions

Editor:

On May 31, 2007, the FDA issued a "Preliminary Public Health Notification: *Acanthamoeba* Keratitis Infections Potentially Related to Complete MoisturePlus Multipurpose Contact Lens Solution Manufactured by Advanced Medical Optics (AMO)." The purpose of the notification was to inform health care practitioners and consumers about the recall of AMO Complete MoisturePlus contact lens disinfecting solution (announced May 25, 2007) and provide recommendations for contact lens wearers.

It has recently come to our attention that there are many consumers who are still not aware of the recall and continue to use the recalled product. Several cases of *Acanthamoeba* keratitis have been reported to the Centers for Disease Control and Prevention (CDC) that involve the use of AMO Complete MoisturePlus after the recall was announced.

While we believe the product has been removed from retailer shelves, many consumers "stock up" on

solution and have multiple bottles of solution at home.

We are asking for your help, and the help of your members, to get this information out to consumers who may be using AMO Complete MoisturePlus. The original notification can be found at [www.fda.gov/cdrh/safety/053107-acanthamoeba.html](http://www.fda.gov/cdrh/safety/053107-acanthamoeba.html). Information written specifically for consumers can be found at [www.fda.gov/cdrh/medicaldevicesafety/atp/053107-acanthamoeba.html](http://www.fda.gov/cdrh/medicaldevicesafety/atp/053107-acanthamoeba.html). Information from the CDC can be found at [www.cdc.gov/ncidod/dpd/parasites/acanthamoeba](http://www.cdc.gov/ncidod/dpd/parasites/acanthamoeba).

Thank you very much for your help in getting this important information more widely disseminated.

Nancy Pressly  
FDA Center for Devices and Radiological Health

### Support allies in public health

Editor:

Optometry is now a major health care provider in the field of public health, and our involvement continues to grow. It was only 52 years ago that optometrists were first able to join the American Public Health Association

(APHA). At that time there were no separate sections for optometrists, and most joined the Medical Care Section. It took 24 years for optometry and other eye care providers to have their own section, now known as the Vision Care Section (VCS).

Over 25 resolutions have been submitted by the VCS and approved by the APHA Governing Council. These resolutions range from their support of optometrists to use both diagnostic and therapeutic drugs to the use of protective eyewear for children engaged in sports activities which have been instrumental in shaping state and national vision policy.

In 2000, the U.S. Department of Health and Human Services released the health promotion and disease prevention initiatives for the nation known as Healthy People 2010. The initiatives contain 10 objectives on vision, and recognize the optometric profession as a leading health care provider in carrying out these initiatives.

In fact, on Jan. 16, 2005, the AOA was commended by the deputy assistant secretary for health for its role in developing the Healthy Eyes Healthy People™ program. In

addition, the AOA also has a Memorandum of Understanding with the APHA, to improve access to vision care services. The MOU has resulted in the Executive Director of the APHA speaking to the AOA House of Delegates for the past few years.

Since 2004, the AOA has distributed \$620,000 to state associations for 144 projects, directly related to the Healthy People 2010 initiatives, including funding from the NEI. These accomplishments are a direct result of the efforts of a small group of dedicated optometrists who were determined to create their own section, and ultimately received support and recognition by the APHA, as the major eye care provider in the U.S.

In 1991, the Governing Council of the APHA unanimously defeated a resolution by ophthalmology to rescind the APHA 1990 resolution favoring the use of therapeutic agents by optometrists. At

that time the Vision Care Section had a membership of 800, as well as four representatives in the Governing Council. Today there are fewer than 400 members and only two members in the governing council. **Our clout has diminished at the very time when optometry is in need of support from external organizations.**

Never in the history of optometry has it been more important for ODs to belong to the APHA. It is time for all optometrists to recognize that we are part of the public health system. Being a member of the American Public Health Association is a confirmation of your understanding and involvement.

Please contact me immediately at my e-mail address, and I will facilitate your membership in this great organization.

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# CMS: Check NPI records for Social Security numbers

The U.S. Centers for Medicare and Medicaid Services (CMS) is urging practitioners to check their National Provider Identifier (NPI) registration information and delete any non-required information they do not wish to have made publicly available.

The CMS notes that a number of health care providers have listed Social Security numbers or other provider identification numbers in the "Other Names" and "Other Provider

Identifier" boxes on the National Plan and Provider Enumeration System (NPPES) registration form, used to apply for NPI numbers.

Experts warn such identifiers can be misused by identity thieves.

The CMS plans to make information in the NPPES databank publicly available through an online NPI Registry.

The NPI Registry will provide information on all NPPES information required for release under the federal

Freedom of Information Act (known as FOIA-disclosable data).

The CMS is delaying the launch of the NPI Registry, which it had hoped to have online by this month. While Social Security numbers are not required on NPI applications they will be required to release the numbers through the NPI Registry if they are part of the NPPES records.

NPI registration information can be checked and revised on the NPPES Web site ([www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)).

## No PINs, UPIN on NPI applications

In a related advisory last month, CMS emphasized that when Medicare physicians or other health care practitioners are applying for an NPI, they should not include their UPIN numbers (if assigned) or their PIN numbers.

Similarly, health care providers associated with group practices or clinics, should not include the PINs for those practice or clinics.

Medicare group practices or clinics applying for NPIs should not include their PINs. They also should not include the PINs or UPINs of any of the members of the group practice or clinic.

## Watch for potential problem areas:

### Incorrect NPPES data can lead to Medicare claim rejections

The CMS recommends health care providers check any information they have entered in the NPPES for accuracy. Some provider information in the NPPES system is used by Medicare in processing claims. If the information entered in NPPES is not correct, claims may be rejected, the CMS notes.

"It is important to verify that information was entered correctly," the CMS warns in a special edition *Medicare Learning Network* article (SEO725) issued July 5. The agency also advises health care providers to "be sure their staff are aware of the key elements that need to be correct ..."

As Medicare has begun to implement the NPI into its systems, several common enumeration and billing errors have been identified that may result in claim rejections, according to the CMS:

- ❖ Errors in the Employer Identification Number (EIN),
- ❖ Invalid or incomplete data within the 'Other Provider Identifiers' section of the NPPES online application,

- ❖ Reporting an incomplete identifier,
- ❖ Having more than the allowable number of legacy numbers,
- ❖ Listing legacy numbers that do not belong to the applicant.

Medicare providers who determine they should make changes in their NPPES records can update the information on the NPPES Web site (<https://nppes.cms.hhs.gov>). They can also send updates on the paper NPI Application/Update Form (CMS-10114), which can be requested by calling the NPI Enumerator at (800) 465-3203, or downloaded from the CMS Forms Web page ([www.cms.hhs.gov/cmsforms](http://www.cms.hhs.gov/cmsforms)).

The new CMS article also offers guidance on a number of other NPI-related topics including: common errors in reporting change of ownership to Medicare and "dos and don'ts" for reporting other provider identification numbers. The article can be viewed on the CMS Web site at [www.cms.hhs.gov/MLNMattersArticles/downloads/SEO725.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/SEO725.pdf).

### Some clearinghouses removing NPIs, error notices

Health care providers who use billing services to file their Medicare claims should be aware that some services are apparently removing NPI numbers from claims, according to the CMS. In addition, some are failing to forward NPI-related error messages from carriers to providers, the agency also warned.

Either could mean some providers will be caught unprepared and facing claim rejections when NPIs become mandatory on Medicare claims, perhaps later this year.

Moreover, removing NPIs from claims could cause health care providers to lose Medicare Physician Quality Report Initiative (PQRI) bonuses right now, the agency added.

The CMS is asking health care providers to file claims with both NPIs and legacy numbers, in part, to help providers, billing services and Medicare carriers identify any problems associated with NPI use before the new identifier becomes required on Medicare claims.

When clearinghouses strip the NPI from claims prior to processing, they cost their clients, carriers and themselves valuable opportunities to spot potential problems, according to the CMS.

"Providers may be under the false impression that their claims are being successfully submitted to Medicare, through their clearinghouse, using an NPI," the CMS noted in a bulletin last month. "During this testing and implementation phase for the NPI, providers should pay close attention to information from health plans and clearinghouses to understand how claims are

being processed and what providers should be doing to ensure no disruption in payment."

Similarly, when clearinghouses remove NPI-related error messages from the remittance advice, they cost their clients opportunities to correct problems with NPI use in their offices, the CMS said.

Because Medicare claims are still being processed primarily on the basis of Medicare provider numbers, claims may be paid even when they have NPI-related errors that will eventually prompt claim rejection.

"Providers should ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses who may be submitting the claims on their behalf," the CMS bulletin continued.

NPIs are already required for participation in the Medicare PQRI, which began July 1.

Under PQRI, health care providers can earn bonuses equaling 1.5 percent of their total Medicare payments for the year when they report specified quality of care measures in at least 80 percent of applicable cases.

Claims filed without NPIs will not be considered when PQRI bonuses are tabulated, the CMS warned.

"Stripping of NPIs (from claims) may be occurring even though the NPI appears on remittance advice because some clearinghouses are adding the NPI to the remittance prior to sending it to the provider," the CMS warned.

# Texas OD finds cataracts during InfantSEE® visit

Sometimes it's a gut feeling, despite a healthy birth and a normal family history, that makes a parent schedule an InfantSEE® assessment, as one Texas family discovered in June.

The mother brought in her 5-month-old son, accompanied by his grandmother and brother. She indicated her concern that the child only seemed to look at things with his head tilted back.

The family practitioner had told the family not to worry about visual problems until the baby was 6 months old.

"The grandma decided to do some research online, where she found the InfantSEE® program and the Dr. Locator," said John Todd Cornett, O.D.

Dr. Cornett's information registered as a search result. Several family members were patients of Dr. Cornett's, so they were comfortable scheduling an InfantSEE® assessment in his office.

After seeing the InfantSEE® assessment listed on the schedule for Dr. Cornett, his new associate, Shauna Thornhill, O.D., a recent Pacific College of Optometry graduate, asked to observe as she had never been involved in a young infant evaluation.

"As we talked, I was thinking that he looked like he couldn't see," said Dr. Cornett. "His mom said he really only liked to look at lights. I noticed an occasional nystagmus. I picked up my transilluminator, and that's when my heart sank. I looked at his beautiful blue eyes, and there was something odd inside his pupils. They were both really grey. I grabbed my ophthalmoscope, and there was just a faint ring of a red reflex that I could only see with a very eccentric view. The majority of his pupil was totally blocked by a dense cataract in each eye."

After dilation, Dr. Cornett could see a few retinal vessels around the edge of the dense cataracts.

The local pediatric ophthalmologist was able to see the infant within two hours and scheduled the first cataract

removal for the following week.

Dr. Cornett was quick to point out to Dr. Thornhill that this was not a typical InfantSEE® assessment. "If everything else is okay, the prognosis is good," said Dr. Cornett. "All it took was a penlight and someone paying attention."

Dr. Cornett credits the InfantSEE® framework that helps to keep babies from falling through the cracks.

"What I'll remember most is that little guy," said Dr. Cornett. "To be his advocate, and not get anything in return, that's pretty cool."

For more information about the InfantSEE® program, or to sign up as an InfantSEE® provider, e-mail [infantsee@aoa.org](mailto:infantsee@aoa.org), call (800) 365-2219, ext. 4286, or visit [www.aoa.org](http://www.aoa.org).

## President

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ments AOA has developed with federal government agencies and like-minded organizations further demonstrate our credibility, clout and overall commitment to patient care.

Boelcke's Dicta is nearly 100 years old, but the principles laid down by this first German Ace hold true today in the legislative arena, business and, unfortunately, in war. Optometry, through the American Optometric

Association, will continue to aggressively pursue legislation that improves the visual welfare of all the citizens of this country and, at the same time, solidifies our profession's rightful place at the frontline of all eye care.

*Kevin L. Alkender OD, PhD*

## Executive Director

The American Optometric Association is seeking an experienced Executive Director. The Executive Director serves the American Optometric Association as its Chief Executive Officer, administering the business and other affairs and overall management of the association. The Executive Director recommends the formulation of new policies to the Board of Trustees, provides policy and program leadership and implements approved policy within existing guidelines approved by the Board of Trustees and/or the House of Delegates. The Executive Director coordinates staff of approximately 100 employees in carrying out programs and activities of the association to meet the objectives established by the Board of Trustees.

It is incumbent upon the Executive Director to maintain effective internal relationships with the staff, and create collaborative external relationships with affiliated associations, allied optometric associations, industry and associations related to the ophthalmic and health care field. The Executive Director will provide leadership in assisting the association to effectively address the interests and concerns of the profession. The Executive Director will also strive to achieve efficient productive performance at all levels within the association structure and provide programming to meet short-term and long-term goals of the association and the profession.

The ideal candidate will have demonstrated leadership experience in managing people, excellent supervisory skills, and superior public speaking ability. Successful candidate will also possess excellent negotiation skills and a high degree of integrity; organizational skills, the ability to manage multiple priorities, and excellent written and verbal communication skills. Position holder must be able to travel extensively. An undergraduate degree with several years' experience in a senior management position is required. An extensive background within the ophthalmic community and optometry is strongly preferred. Graduate work in health sciences and association management would be desirable. Excellent benefits. Qualified applicants please forward your resume with salary history and requirements to: [HumanResources@AOA.org](mailto:HumanResources@AOA.org).

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For more information about the American Optometric Association, visit our Web site at [www.aoa.org](http://www.aoa.org).



## AOA site offers one-stop PQRI tutorial

A new Medicare Physician Quality Reporting Initiative (PQRI) page on the AOA Web site offers a convenient, comprehensive summary of the information optometrists most need to participate in Medicare's new quality reporting program.

Under the Medicare PQRI, health care practitioners can earn 1.5 percent payment bonuses when they take specified measures to enhance care for Medicare beneficiaries and report those services on claims using a new set of Level II CPT codes.

The AOA PQRI page was redesigned to coincide with the July 1 start of the first Medicare PQRI reporting period.

It reflects last-minute guidance from the U.S. Centers for Medicare and Medicaid Services (CMS). The Web page covers:

- ❖ An introduction to the PQRI for optometrists
- ❖ How to code for eye care measures

- ❖ PQRI coding definitions
- ❖ PQRI tools and resources from the CMS, AOA and other sources (including documentation materials for macular degeneration, diabetic retinopathy and activities of daily living)
- ❖ PQRI eye care measures on a convenient summary
- ❖ Filing specifics and examples for each of the measures
- ❖ CMS PQRI PowerPoint presentations
- ❖ An explanation of the PQRI incentive payment
- ❖ PQRI Beyond 2007: plans for the development of the PQRI in the future; and
- ❖ CMS special alerts and announcements regarding the PQRI are posted to the Web page on release.

The new AOA PQRI page was developed by the AOA Eye Care Benefits Center and AOA Federal Relations Committee with the assistance of the AOA Communications Group.

AOA members are urged to check the PQRI page frequently for updates on the

program.

AOA members can find a link to the new PQRI page on the AOA Web site home page ([www.aoa.org](http://www.aoa.org)) or log on directly at [www.aoa.org/PQRI.xml](http://www.aoa.org/PQRI.xml).

## Letter explains PQRI to beneficiaries

The Centers for Medicare and Medicaid Services (CMS) has developed a letter to Medicare beneficiaries with important information about the Physician Quality Reporting Initiative (PQRI).

The letter explains what the program is and its implications for patients. Physicians may provide copies of the letter to their patients in support of their PQRI participation.

To access the letter, visit the CMS PQRI page ([www.cms.hhs.gov/PQRI](http://www.cms.hhs.gov/PQRI)), scroll to the "Downloads" section and selected the link to the "Letter to Medicare Beneficiaries."



# Now there is something new, Red Tray.

As the owner of a small to medium practice, you know the best way to save on your 'cost of goods' has always been to concentrate your purchases with a few key suppliers and buy the rest of your products through a traditional buying group. But unless you do a lot of volume, that still doesn't get you the maximum discount offered by most optical labs and frame companies.

## Get the buying power of a mega practice.

Founded by Jerry Hayes, OD, Red Tray offers you the maximum published discount from a select group of top optical labs and frame companies. And, unlike traditional buying groups, we don't hold back any of the discount. You get it all!

As a Red Tray member, you don't have to own a chain of offices or have a Million Dollar practice to get the maximum published discount on every lab purchase and every frame you buy — regardless of your monthly volume. Getting thousands of dollars in extra discounts could be as simple as billing your lab purchases through Red Tray.

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At right, are just a few of the discounts Red Tray members receive from America's best labs and top frame companies. For a complete 'at-a-glance' comparison of Red Tray discounts by lab and individual designer line, call Linda Holley at **800.416.7676, Ext 292**.

## How do we offer such great discounts?

First off, we create buying power by signing up thousands of dispensing practices across the country. Then we cut our margins to the bone by charging members an admin fee as low as 1% of their purchases. Go to [www.redtraysaves.com](http://www.redtraysaves.com) for a complete explanation of our discount structure and see how you can benefit from the strongest discount plan ever offered to independent practice owners.

## Buy from Red Tray preferred suppliers and add thousands to your bottom line.

Membership is FREE.  
Call 800.416.7676 or go to  
[www.redtraysaves.com](http://www.redtraysaves.com)



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**SAME suppliers.  
SAME products.  
BETTER discounts.**

**Typical  
Buying  
Group**

**Your  
Red Tray  
Discount**

**Compare  
and save:**

### Sample Frame Discounts

15%	<b>18%</b>	<b>Aspex Eyewear</b>
16%	<b>20%</b>	<b>Charmant Group*</b>
15%	<b>20%</b>	<b>ClearVision Optical*</b>
16%	<b>20%</b>	<b>L'Amy Group</b>
17%	<b>20%</b>	<b>Luxottica Group*</b>
17%	<b>20%</b>	<b>Marchon Eyewear*</b>
17%	<b>20%</b>	<b>Marcolin Eyewear*</b>
7%	<b>10%</b>	<b>ProDesign Eyewear*</b>
13%	<b>17%</b>	<b>REM Eyewear</b>
20%	<b>20%</b>	<b>Revolution Eyewear</b>
15%	<b>20%</b>	<b>Safilo Group*</b>
10%	<b>15%</b>	<b>Signature Eyewear*</b>
6%	<b>10%</b>	<b>Silhouette</b>
8%	<b>12.5%</b>	<b>Tura Optical*</b>
16%	<b>20%</b>	<b>Viva Group*</b>

*Discounts are off list. \*Maximum discounts vary by individual designer lines.*

### Sample Lab Discounts

20%	<b>24%</b>	<b>Bell-Duffens Optical*</b>
10%	<b>15%</b>	<b>Central Optical</b>
20%	<b>24%</b>	<b>Crown Optical - RI*</b>
20%	<b>24%</b>	<b>DBL Labs*</b>
20%	<b>24%</b>	<b>Duffens Optical*</b>
20%	<b>24%</b>	<b>East Coast Ophthalmic*</b>
20%	<b>24%</b>	<b>Elite Optical - Visalia*</b>
20%	<b>24%</b>	<b>Essilor New Jersey*</b>
15%	<b>25%</b>	<b>Eye-Kraft</b>
16%	<b>20%</b>	<b>HOYA Dallas</b>
16%	<b>20%</b>	<b>HOYA Hartford</b>
16%	<b>20%</b>	<b>HOYA Seattle</b>
Silver Level	<b>Gold Level</b>	<b>IcareLabs</b>
5%	<b>10%</b>	<b>Interstate Optical*</b>
17%	<b>20%</b>	<b>Luzerne Optical</b>
20%	<b>24%</b>	<b>Meridian - Phoenix*</b>
20%	<b>24%</b>	<b>Milroy Optical*</b>
20%	<b>24%</b>	<b>New City Optical*</b>
20%	<b>24%</b>	<b>Omega Dallas*</b>
20%	<b>24%</b>	<b>Optical Supply Inc.*</b>
14%	<b>25%</b>	<b>Pech Optical</b>
20%	<b>24%</b>	<b>Precision Optics*</b>
15%	<b>20%</b>	<b>Rite-Style Optical</b>
15%	<b>20%</b>	<b>Robertson Optical</b>
20%	<b>24%</b>	<b>Southern Optical*</b>
10%	<b>15%</b>	<b>Sutherlin Optical</b>
20%	<b>24%</b>	<b>Top Network - Ohio*</b>
20%	<b>24%</b>	<b>Twin City Optical*</b>

*Discounts are off list. \*Discounts are off National Price List.*

**For a complete list of frame and lab discounts, call or go to:  
[www.redtraysaves.com](http://www.redtraysaves.com)**



# 2007 AOA Optical Dispensing Survey

## Most patients still getting eyeglasses, CLs from their ODs

Optical shops, Internet retailers, and telephone merchandisers often claim big discounts for eyeglass and contact lens wearers. However, vision care patients are not flocking in increasing numbers to have their eyewear prescriptions filled outside their optometrists' offices, the 2007 AOA Optical Dispensing Survey finds.

In fact, contact lens patients now appear to be a bit more likely to purchase their lenses from their eye care providers than in the recent past, the survey shows.

Patients in AOA member practices are obtaining their eyeglasses through practice dispensaries and "alternative sources" at about the same rates as they were six years ago, notes AOA Information and Data Committee Chair Richard C. Edlow, O.D.

Only 14.3 percent of patients examined in AOA-member practices took spectacle prescriptions outside the practice to be filled last year — exactly the same percentage as in 2000, the survey finds.

The percentage of contact lens patients purchasing their lenses outside the practice, following an examination in an AOA-member practice, actually decreased to 17 percent last year, down from 21 percent in 2004.

"This suggests optometric practices are doing a good job of providing quality, value and service. Most patients do not find reason to take their prescriptions elsewhere to be filled," Dr. Edlow said.

Traditionally, most vision care patients have purchased their eyeglasses and contact lenses through their eye care practitioners' dispensaries. However, some optical industry observers have anticipated continuing erosion in practice dispensary business due to aggressive price-oriented

### Patients Requiring Spectacle Prescriptions/ Spectacle Rx's Filled Elsewhere

Mean Percent, 1992-2006

Category	1992	1994	1998	2000	2002	2004	2006
Required new Rx*	69.1	69.3	69.5	69.9	64.9	62.6	63.5
Did not require new Rx**	20.0	20.3	20.3	20.3	24.2	25.6	25.0
Did not require any Rx	10.9	10.4	10.2	9.8	10.9	11.8	11.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Rx's filled elsewhere	11.9	11.5	12.7	14.3	13.6	15.0	14.3

\* First time Rx or change in existing Rx

\*\* Previous Rx adequate

advertising by telephone order firms, Internet lens sellers and discount optical shops.

Federal and state laws, such as the *Fairness to Contact Lens Consumers Act of 2004*, which require eye

a number of factors when purchasing eyewear, including quality, convenience, style and the confidence they place in their eye care practitioners. For most patients, price will not be the sole consideration in the purchase.

*Contact lens patients now appear to be a bit more likely to purchase their lenses from their eye care providers than in the recent past.*

care practitioners to release copies of vision correction prescriptions to patients, were also expected to contribute to that trend.

However, the AOA survey data suggests use of alternative lens sources may have reached a plateau.

Optometric practice management consultants note that patients are likely to consider

Moreover, state laws requiring prescription release have been in place for years, and their effects on the market have probably already been realized, according to the AOA Advocacy Group.

The AOA Optical Dispensing Survey is conducted every two years to track trends in eyewear dispensing among AOA member

optometric practices. It is a stratified random sample of 4,000 practices reflecting activities in calendar year 2006.

Among the survey's other findings:

❖ Utilization of traditional glass lenses continues to decline, while high-index plastic lenses saw "a nice jump" in popularity over the past two years — now representing 21.8 percent of the lenses dispensed by AOA members, according to Dr. Edlow.

"More significantly, polycarbonate lenses now represent 31.3 percent as newly introduced polycarbonate products are being embraced by optometrists, particularly for children's eyewear in light of their superior safety," Dr. Edlow said.

❖ Progressive lenses are now dispensed twice as often as traditional flat-top bifocals.

❖ Some 48 percent of AOA member practices now

provide lens edging, up from 40 percent two years ago.

❖ More AOA member practices now offer lens surfacing (5.7 percent) and lens casting (5.5 percent).

❖ Soft torics now represent 21 percent of the contact lenses dispensed in AOA member practices, up from 17 percent in 2004.

❖ Soft multifocals now represent 9.4 percent of the contact lenses dispensed in AOA member practices, up from 7.4 percent in 2004.

"That reflects better product, improved ease of fit, and practitioners getting more involved in providing the very latest in lens modalities available," Dr. Edlow said.

The complete text of the AOA Information and Data Committee survey will appear in the Practice Strategies section of the October issue of *Optometry: Journal of the American Optometric Association*.

### OD Dispensed Lenses with One or More Treatments, Mean Percent, 1994-2006

Type of Lens Treatment*	1994	1998	2000	2002	2004	2006
Scratch-resistance coating	60.4	63.1	69.1	67.2	62.9	66.5
Ultra-violet coating	32.6	34.2	38.1	36.1	33.5	40.4
Tinting (excl. photochromic)	34.9	24.0	18.0	16.3	15.6	12.4
Photochromic lenses**	14.2	22.7	22.4	23.1	24.6	25.0
Anti-reflective	11.0	16.0	24.9	25.8	27.2	36.8
Polarized	2.9	4.3	7.1	8.1	8.3	9.9

\* totals may exceed 100 percent

\*\* includes Transitions, glass photochromic, etc.



# Survey: anti-reflectives catching on in U.S

For years, anti-reflective coating has been all but standard on eyeglasses in Europe and Asia. Now, a new AOA survey finds anti-reflectives may finally be catching on in the United States.

For the first time, last year, fully one-third of eyeglasses dispensed in AOA-member optometric practices had anti-reflective coatings, according to the new 2007 AOA Optical Dispensing Survey.

Utilization of anti-reflective coating has more than tripled since 1994, the survey shows. More significantly, it increased 9.6 percent over the past two years, according to AOA Information and Data Committee Chair Richard C. Edlow, O.D.

That is "the biggest change in a two-year period that we have ever seen," Dr. Edlow noted.

In Europe and Asia, 90 percent of eyeglasses have anti-reflective lenses, according to Dr. Edlow.

The optical industry has long wondered why anti-reflective lens treatments have not enjoyed similar popularity in North America.

Dr. Edlow speculates that growth in anti-glare coating utilization could reflect increased patient interest in eyewear quality and style.

"In Europe, and particularly in Italy, there is much more interest in eyeglasses as a fashion statement. People have three or four glasses for different days of the week. As opposed to the U.S. where patients buy one pair and hope they last for six years," Dr. Edlow said.

That theory would be consistent with other survey findings that show frames in AOA members' dispensaries now average from \$45 to \$80 and continue to trend toward the upper end of the price range, Dr. Edlow observes.

He also suspects more optometrists and more practice staff members may be embracing anti-reflective lens technology.

"The AOA Optical Dispensing Survey confirms that optometrists and their staffs are instrumental in

helping patients to decide which lens options best meet their individual needs," Dr. Edlow notes.

In well over half of cases (57.2 percent), anti-reflective coating is recommended to patients by optometrists.

In about four out of five

cases (39.9 percent), it is recommended to patients by optometric office staff.

In only 3.3 percent of cases, do patients bring up the subject of anti-reflective lenses.

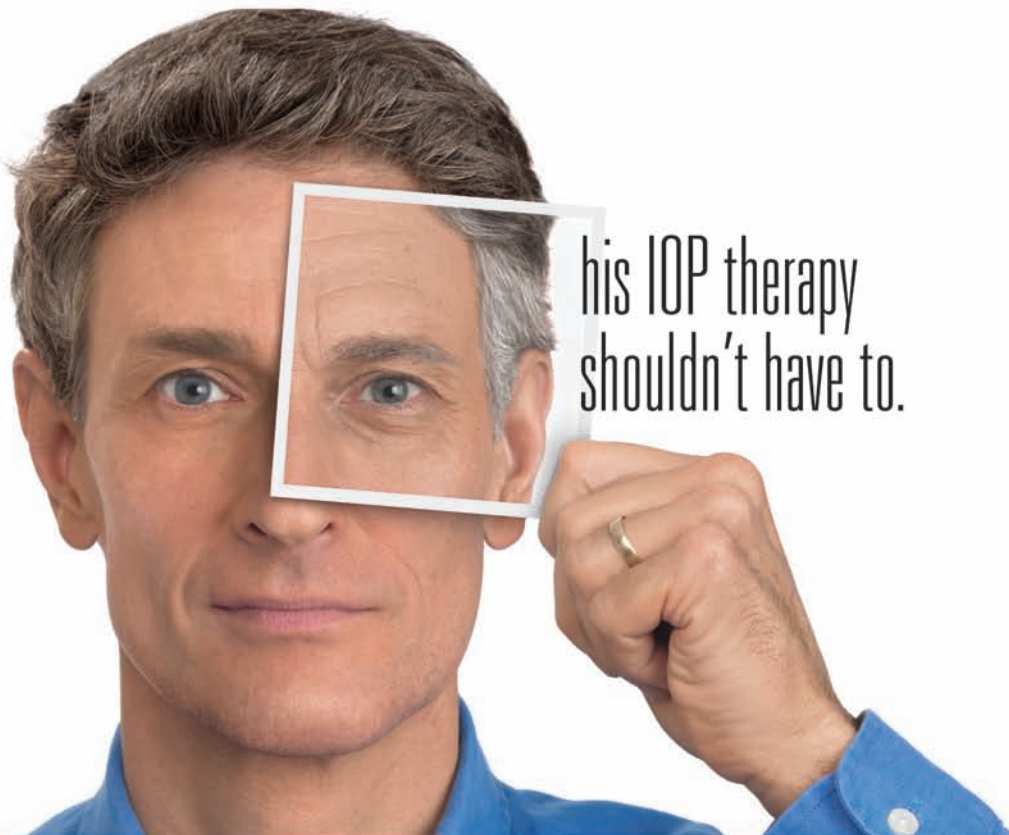
Whatever the reason, Dr. Edlow believes the increase

in anti-reflective coating utilization is good news for U.S. eye care patients.

"In my opinion as a doctor of optometry, the clarity of vision is so far superior that they should be prescribed for everyone," Dr. Edlow said.

In the treatment  
of elevated IOP:

His looks  
may change...



his IOP therapy  
shouldn't have to.

## PROVEN THERAPY your patients can start and stay with

- Powerful efficacy<sup>1-5</sup>
- Proven tolerability<sup>1, 3-6</sup>
- Demonstrated persistency<sup>7-9</sup>

The #1 prescribed IOP-lowering agent and the only PG\* with more than 10 years of physician experience<sup>10†</sup>



\* PG class includes XALATAN, bimatoprost, and travoprost.

† XALATAN was approved by the Food and Drug Administration in 1996 and has had more than a decade of marketing experience.

IOP = intraocular pressure.

PG = prostaglandin.

XALATAN is indicated for the reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OH).

**Important Safety Information:** XALATAN can cause changes to pigmented tissues. Most frequently reported are increased pigmentation of the iris, periorbital tissue (eyelid) and eyelashes, and growth of eyelashes. Pigmentation is expected to increase as long as XALATAN is administered. Iris pigmentation is likely to be permanent while eyelid skin darkening and eyelash changes may be reversible. The effects beyond 5 years are unknown. Most common ocular events/signs and symptoms (5% to 15%) reported with XALATAN in the three 6-month registration trials included blurred vision, burning and stinging, conjunctival hyperemia, foreign-body sensation, itching, increased iris pigmentation, and punctate epithelial keratopathy. XALATAN should be used with caution in patients with a history of intraocular inflammation (iritis/uveitis) and should generally not be used in patients with active intraocular inflammation. XALATAN should be used with caution in aphakic patients, in pseudophakic patients with a torn posterior lens capsule, or in patients with known risk factors for macular edema. The recommended dosage of XALATAN is one drop (1.5 µg) in the affected eye(s) once daily in the evening. If one dose is missed, treatment should continue with the next dose as normal. The dosage of XALATAN should not exceed once daily; the combined use of two or more prostaglandins, or prostaglandin analogs including XALATAN, is not recommended. It has been shown that administration of these prostaglandin drug products more than once daily may decrease the intraocular pressure-lowering effect or cause paradoxical elevations in IOP. There have been reports of bacterial keratitis associated with the use of multiple-dose containers of topical ophthalmic products.

Please see brief summary of prescribing information and references on next page.

XLU00144

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June 2007







**New officers of the AOA Paraoptometric Section, from left, Immediate Past President Barbara Wohlk, CPOT; Trustee Teresa Stokes, CPOT; Trustee Mary-Ellen Breen, CPOA; Secretary Mary Dunn, CPOT; Vice Chair Shoni Sharp, CPOT; Chair-elect Nora Dorau, CPOA; Chair Sue McAteer, CPOT, and swearing in the new officers, Dennis Lyons, O.D.**

# Take time to recognize paraoptometrics

The AOA Paraoptometric Section, with the support of the AOA, has designated Sept. 16-22, 2007, as Paraoptometric Recognition Week. Now in its sixth year, the recognition week is designed to honor paraoptometrics for

their dedication to the patients they serve and to the profession of optometry.

“On a daily basis, paraoptometrics provide extensive patient care, as well as office organization, allowing the optometrists to concentrate their efforts on the care of each patient,” said Kevin L. Alexander, O.D., Ph.D., AOA president. Recognition of paraoptometry as a profession hinges on the strength of the paraoptometric members and support of optometrists and other health care providers.

By seeking education, acquiring new skills and becoming certified, the high standards for paraoptometrics challenge other support personnel who work within the profession to do the same, according to the AOA Paraoptometric Section. Sue McAteer, CPOT, chair of the AOA Paraoptometric Section, emphasizes that the success of the Paraoptometric Recognition Week depends also on doctor participation. This recognition is another opportunity to build on the great team relationship between optometrists and paraoptometrics.

The AOA Paraoptometric Section suggests a variety of ways to celebrate the week and provides Paraoptometric Recognition Week Promotional Kits free of charge to help in making plans for the observance. Kits may be requested by e-mailing [jvmurphy@aoa.org](mailto:jvmurphy@aoa.org). Doctors are encouraged to be creative in planning their festivities.

Suggestions include: providing a Paraoptometric Section membership for a paraoptometric in the office, treating staff to lunch or dinner, outfitting staff with AOA apparel and gift items, gift certificates, flowers or candy. The activity or gesture may be big or may be quietly expressed; either way, doctors are urged to participate in this opportunity to extend appreciation to paraoptometrics.

## Xalatan®

latanoprost ophthalmic solution  
0.005% (50 µg/mL)

### BRIEF SUMMARY

Before prescribing, please consult full prescribing information.

### INDICATIONS AND USAGE

XALATAN Sterile Ophthalmic Solution is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

### CONTRAINDICATIONS

Known hypersensitivity to latanoprost, benzalkonium chloride or any other ingredients in this product.

### WARNINGS

XALATAN Sterile Ophthalmic Solution has been reported to cause changes to pigmented tissues. The most frequently reported changes have been increased pigmentation of the iris, periorbital tissue (eyelid) and eyelashes, and growth of eyelashes. Pigmentation is expected to increase as long as XALATAN is administered. After discontinuation of XALATAN, pigmentation of the iris is likely to be permanent while pigmentation of the periorbital tissue and eyelash changes have been reported to be reversible in some patients. Patients who receive treatment should be informed of the possibility of increased pigmentation. The effects of increased pigmentation beyond 5 years are not known.

### PRECAUTIONS

**General:** XALATAN Sterile Ophthalmic Solution may gradually increase the pigmentation of the iris. The eye color change is due to increased melanin content in the stromal melanocytes of the iris rather than to an increase in the number of melanocytes. This change may not be noticeable for several months to years (see **WARNINGS**). Typically, the brown pigmentation around the pupil spreads concentrically towards the periphery of the iris and the entire iris or parts of the iris become more brownish. Neither nevi nor freckles of the iris appear to be affected by treatment. While treatment with XALATAN can be continued in patients who develop noticeably increased iris pigmentation, these patients should be examined regularly.

During clinical trials, the increase in brown iris pigment has not been shown to progress further upon discontinuation of treatment, but the resultant color change may be permanent.

Eyelid skin darkening, which may be reversible, has been reported in association with the use of XALATAN (see **WARNINGS**).

XALATAN may gradually change eyelashes and vellus hair in the treated eye; these changes include increased length, thickness, pigmentation, the number of lashes or hairs, and misdirected growth of eyelashes. Eyelash changes are usually reversible upon discontinuation of treatment.

XALATAN should be used with caution in patients with a history of intraocular inflammation (iritis/uveitis) and should generally not be used in patients with active intraocular inflammation.

Macular edema, including cystoid macular edema, has been reported during treatment with XALATAN. These reports have mainly occurred in aphakic patients, in pseudophakic patients with a torn posterior lens capsule, or in patients with known risk factors for macular edema. XALATAN should be used with caution in patients who do not have an intact posterior capsule or who have known risk factors for macular edema.

There is limited experience with XALATAN in the treatment of angle closure, inflammatory or neovascular glaucoma. There have been reports of bacterial keratitis associated with the use of multiple-dose containers of topical ophthalmic products. These containers had been inadvertently contaminated by patients who, in most cases, had a concurrent corneal disease or a disruption of the ocular epithelial surface (see **PRECAUTIONS, Information for Patients**).

Contact lenses should be removed prior to the administration of XALATAN, and may be reinserted 15 minutes after administration (see **PRECAUTIONS, Information for Patients**).

**Information for Patients** (see **WARNINGS** and **PRECAUTIONS**): Patients should be advised about the potential for increased brown pigmentation of the iris, which may be permanent. Patients should also be informed about the possibility of eyelid skin darkening, which may be reversible after discontinuation of XALATAN.

Patients should also be informed of the possibility of eyelash and vellus hair changes in the treated eye during treatment with XALATAN. These changes may result in a disparity between eyes in length, thickness, pigmentation, number of eyelashes or vellus hairs, and/or direction of eyelash growth. Eyelash changes are usually reversible upon discontinuation of treatment.

Patients should be instructed to avoid allowing the tip of the dispensing container to contact the eye or surrounding structures because this could cause the tip to become contaminated by common bacteria known to cause ocular infections. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions. Patients should be advised that if they develop an intercurrent ocular condition (e.g., trauma, or infection) or have ocular surgery, they should immediately seek their physician's advice concerning the continued use of the multiple-dose container.

Patients should be advised that if they develop any ocular reactions, particularly conjunctivitis and lid reactions, they should immediately seek their physician's advice.

Patients should also be advised that XALATAN contains benzalkonium chloride, which may be absorbed by contact lenses. Contact lenses should be removed prior to administration of the solution. Lenses may be reinserted 15 minutes following administration of XALATAN.

If more than one topical ophthalmic drug is being used, the drugs should be administered at least five (5) minutes apart.

**Drug Interactions:** *In vitro* studies have shown that precipitation occurs when eye drops containing thimerosal are mixed with XALATAN. If such drugs are used they should be administered at least five (5) minutes apart.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Latanoprost was not mutagenic in bacteria, in mouse lymphoma or in mouse micronucleus tests.

Chromosome aberrations were observed *in vitro* with human lymphocytes.

Latanoprost was not carcinogenic in either mice or rats when administered by oral gavage at doses of up to 170 µg/kg/day (approximately 2,800 times the recommended maximum human dose) for up to 20 and 24 months, respectively. Additional *in vitro* and *in vivo* studies on unscheduled DNA synthesis in rats were negative. Latanoprost has not been found to have any effect on male or female fertility in animal studies.

**Pregnancy:** Teratogenic Effects: Pregnancy Category C.

Reproduction studies have been performed in rats and rabbits. In rabbits an incidence of 4 of 16 dams had no viable fetuses at a dose that was approximately 80 times the maximum human dose, and the highest nonembryocidal dose in rabbits was approximately 15 times the maximum human dose. There are no adequate and well-controlled studies in pregnant women. XALATAN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** It is not known whether this drug or its metabolites are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when XALATAN is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in pediatric patients have not been established.

**Geriatric Use:** No overall differences in safety or effectiveness have been observed between elderly and younger patients.

### ADVERSE REACTIONS

**Adverse events referred to in other sections of this insert:**

Eyelash changes (increased length, thickness, pigmentation, and number of lashes); eyelid skin darkening; intraocular inflammation (iritis/uveitis); iris pigmentation changes; and macular edema, including cystoid macular edema (see **WARNINGS** and **PRECAUTIONS**).

### Controlled Clinical Trials:

The ocular adverse events and ocular signs and symptoms reported in 5 to 15% of the patients on XALATAN Sterile Ophthalmic Solution in the three 6-month, multi-center, double-masked, active-controlled trials were blurred vision, burning and stinging, conjunctival hyperemia, foreign body sensation, itching, increased pigmentation of the iris, and punctate epithelial keratopathy.

Local conjunctival hyperemia was observed; however, less than 1% of the patients treated with XALATAN required discontinuation of therapy because of intolerance to conjunctival hyperemia.

In addition to the above listed ocular events/signs and symptoms, the following were reported in 1 to 4% of the patients: dry eye, excessive tearing, eye pain, lid crusting, lid discomfort/pain, lid edema, lid erythema, and photophobia. The following events were reported in less than 1% of the patients: conjunctivitis, diplopia and discharge from the eye. During clinical studies, there were extremely rare reports of the following: retinal artery embolus, retinal detachment, and vitreous hemorrhage from diabetic retinopathy.

The most common systemic adverse events seen with XALATAN were upper respiratory tract infection/cold/flu, which occurred at a rate of approximately 4%. Chest pain/angina pectoris, muscle/joint/back pain, and rash/allergic skin reaction each occurred at a rate of 1 to 2%.

### Clinical Practice:

The following events have been identified during postmarketing use of XALATAN in clinical practice. Because they are reported voluntarily from a population of unknown size, estimates of frequency cannot be made. The events, which have been chosen for inclusion due to either their seriousness, frequency of reporting, possible causal connection to XALATAN, or a combination of these factors, include: asthma and exacerbation of asthma; corneal edema and erosions; dyspnea; eyelash and vellus hair changes (increased length, thickness, pigmentation, and number); eyelid skin darkening; herpes keratitis; intraocular inflammation (iritis/uveitis); keratitis; macular edema, including cystoid macular edema; misdirected eyelashes sometimes resulting in eye irritation; dizziness, headache, and toxic epidermal necrolysis.

### OVERDOSAGE

Apart from ocular irritation and conjunctival or episcleral hyperemia, the ocular effects of latanoprost administered at high doses are not known. Intravenous administration of large doses of latanoprost in monkeys has been associated with transient bronchoconstriction; however, in 11 patients with bronchial asthma treated with latanoprost, bronchoconstriction was not induced. Intravenous infusion of up to 3 µg/kg in healthy volunteers produced mean plasma concentrations 200 times higher than during clinical treatment and no adverse reactions were observed. Intravenous dosages of 5.5 to 10 µg/kg caused abdominal pain, dizziness, fatigue, hot flushes, nausea and sweating. If overdosage with XALATAN Sterile Ophthalmic Solution occurs, treatment should be symptomatic.

### DOSAGE AND ADMINISTRATION

The recommended dosage is one drop (1.5 µg) in the affected eye(s) once daily in the evening. If one dose is missed, treatment should continue with the next dose as normal.

The dosage of XALATAN Sterile Ophthalmic Solution should not exceed once daily; the combined use of two or more prostaglandins, or prostaglandin analogs including XALATAN Sterile Ophthalmic Solution is not recommended. It has been shown that administration of these prostaglandin drug products more than once daily may decrease the intraocular pressure lowering effect or cause paradoxical elevations in IOP.

Reduction of the intraocular pressure starts approximately 3 to 4 hours after administration and the maximum effect is reached after 8 to 12 hours.

XALATAN may be used concomitantly with other topical ophthalmic drug products to lower intraocular pressure. If more than one topical ophthalmic drug is being used, the drugs should be administered at least five (5) minutes apart.

### HOW SUPPLIED

XALATAN Sterile Ophthalmic Solution is a clear, isotonic, buffered, preserved colorless solution of latanoprost 0.005% (50 µg/mL). It is supplied as a 2.5 mL solution in a 5 mL clear low density polyethylene bottle with a clear low density polyethylene dropper tip, a turquoise high density polyethylene screw cap, and a tamper-evident clear low density polyethylene overcap.

### 2.5 mL fill, 0.005% (50 µg/mL)

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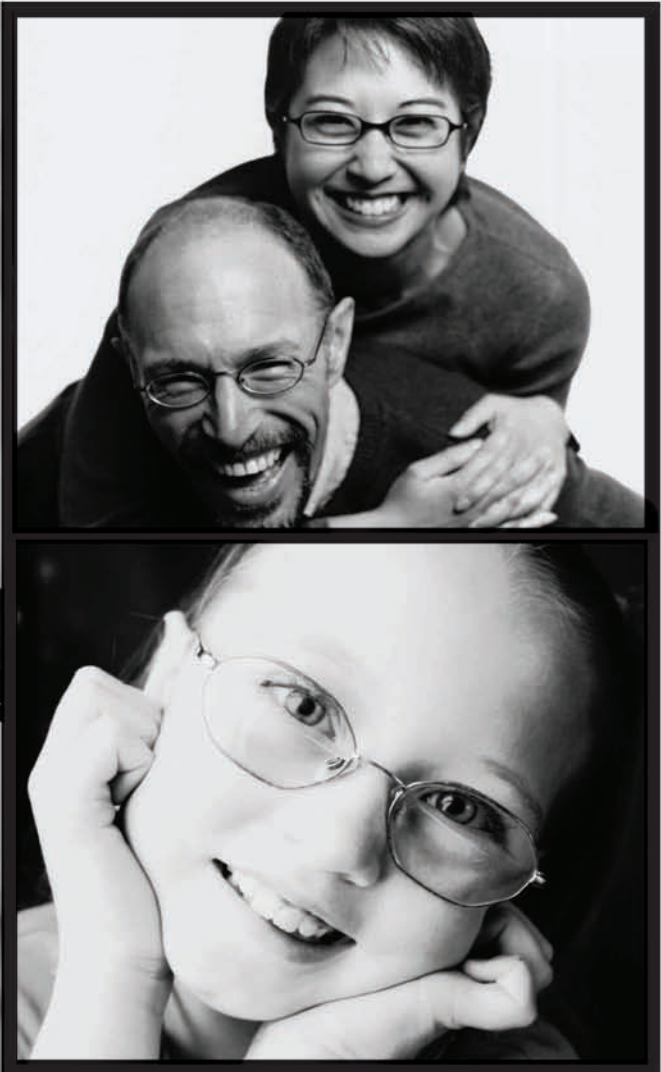
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Revised November 2006

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# Railroad employees national health plan adds optometrists

In a reversal of earlier policy, the Railroad Employees National Health and Welfare Plan announced that coverage for the services of optometrists will be added to the national plan.

Prior to this announcement, only the services of ophthalmologists were covered.

A letter from Robert A. Scardelletti, International president of the Transportation Communications International Union, explained that the policy was reconsidered after contact from several optometrists and others who were "helpful in illustrating the point that

many members live in areas where access to ophthalmologists is limited or non-existent, and that many types of medical treatment involving the eyes can be performed by an optometrist at a lower cost to the plan than an ophthalmologist."

The services of optometrists will be covered under the following conditions:

- ❖ The services must be within the scope of the optometrist's license
- ❖ The service would otherwise be covered if performed by a medical doctor (MD).

Refractive services will continue to be excluded under the medical plan, but are covered under the group's VSP vision plan.

"The success in turning around the Railroad's decision to exclude optometrists (from medical eye care) is an example of what can happen when individual members, state affiliates and the AOA act together using all our resources," said Tom Weaver, DMD, AOA Eye Care Benefits Center director. "Everyone deserves the credit and should be justifiably proud."

## SCHIP

from page 4

five years to expand coverage, but does not include provisions addressing the Medicare fee cut or Medicare Advantage plans.

The funding mechanism of the bill would be a 61-cent increase of the cigarette tax

and a slightly larger increase in taxes on cigars and other tobacco products.

The approval of two different SCHIP reauthorization bills will result in the appointment of a Senate-House conference committee charged

with producing a final version for a final up-or-down vote in each chamber.

President Bush, who has said he will veto any SCHIP-reauthorization bill exceeding \$5 billion in cost, will then get the final bill.

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## Insurance Committee outlines Business Owner's Plan (BOP)

If you are planning to open your own practice, business owner's insurance is second only to professional liability insurance in importance. Business insurance, otherwise known as a Business Owner's Plan (BOP), is general liability protection. It covers the business from specific property risks. These include loss of equipment and premises by fire, theft, and other hazards. The BOP also protects against loss from injury to others. For example, if a client falls and is injured in your office, the plan covers this accident.

Recent columns on this topic appear similar to that of Office Overhead Expense Insurance (OOEI). However, these two programs serve two different purposes. OOEI pays office expenses for the doctor who is unable to work. It is essentially disability insurance, but classified as "health insurance." BOP insures real losses from fire, theft, etc., including injuries. It is classified as "property and casualty insurance."

If you rent space or are employed, always check your liability. If you rent, the owner may cover loss of his or her real property, but not loss of your equipment or supplies. Similarly, the owner's policy may not cover injuries sustained by your patients. Even if you are employed, you should know what your liabilities are. Your employer may not cover all your risks.

If you have a policy, read it to see what is covered and what is not. One optometrist was surprised to learn that he was not covered if a patient was injured while he took her to the parking lot in her wheelchair. While one would expect this situation to be covered, insurance companies are businesses and they cannot afford to cover risks not specified in the policy. The worst time to review your policy is after you have to file a claim.

BOP policies are individually underwritten because there are many variables involved. Specifics of the building must be taken into account – whether there is an increased fire, flood, or hurricane risk, for example, and the construction of the building – size, materials, etc., as well as age of the building. Two rates will be developed – one for the real property and one for the contents.

Business Interruption Insurance is usually a part of the BOP. It covers the actual loss of income for a 12-month period. While the Office Overhead Expense Insurance (mentioned above) covers the loss of the optometrist, Business Interruption Insurance covers the loss of the facility's money-making ability. If the building and/or contents are destroyed in a fire, the loss of income will be covered, even if the doctor is fully capable of working.

Finally, there is the question of where to purchase your BOP. The AOA-endorsed property and casualty provider, Marsh, was chosen because it provides what AOA recognizes to be the best value. We have many members who choose to participate in the AOA-endorsed program. Marsh uses different insurance companies depending on what insurance companies offer in different locations. Other members prefer to enlist the services of a local agent who can provide the insurance and act as a referral source for the doctor.

For more information, contact Marsh at (800) 882-2262 or Tom Weaver at (703) 837-1343 or [TWeaver@aoa.org](mailto:TWeaver@aoa.org). As with any insurance program, specifics need to be discussed with a licensed agent.



# Texas Medicaid patients gain direct access to eye care

**T**exas Gov. Rick Perry (R) signed into law Senate Bill 10, which establishes direct access to eye health care services for Medicaid recipients, including those receiving services through a managed care arrangement, on June 14.

"The new Texas legislation allows for direct access of Medicaid patients to both optometrists and ophthalmologists without going through a primary care physician or another gatekeeper," said Brian J. Blount, O.D., Texas Optometric Association president-elect.

"It will improve patient access to eye care, as well as reduce Medicaid costs. It will also save our patients' time, energy and precious financial resources," he said.

As part of a multifaceted health care reform bill, Medicaid recipients in Texas will now be entitled to select ophthalmologists or therapeutic optometrists who are medical assistance providers to provide eye health care services.

The reform covers services, other than surgery, that are within the scope of services provided under the medical assistance program and within the scope of practice for which the provider is licensed and credentialed.

Medicaid recipients will have direct access to the selected ophthalmologist or therapeutic optometrist for the provision of non-surgical services without any requirement to obtain a referral from a primary care physician or other gatekeeper or any other prior authorization or pre-certification.

This does not expand the scope of eye health care services provided under the medical assistance program.

In addition, Medicaid recipients receiving care under managed care plans will also have direct access to in-network providers — whether they are an ophthalmologist or therapeutic optometrist.

This act will not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms and conditions of the managed care plan.

*"It will improve patient access to eye care, as well as reduce Medicaid costs. It will also save our patients' time, energy and precious financial resources."*




The reluctant glaucoma patient:

## Turning resistance into adherence

**Poor adherence is more prevalent than you might think**

Patients say they take their IOP-lowering drops every day as prescribed, but there's good reason to wonder. In a large, retrospective cohort study that used health insurance claims data from 5300 patients, nearly 50% of patients who were initially dispensed glaucoma medication discontinued their topical ocular hypotensive therapy within 6 months.<sup>1</sup> Only 37% of all patients had their initial prescription refilled within the last 60 to 120 days at 3 years after the initial dispensing.<sup>1</sup>

**Why patients find it hard to adhere**

This apparent inability of patients to properly adhere to topical glaucoma therapy is gaining the attention of many physicians seeking to slow disease progression and preserve the vision of their patients.<sup>2-4</sup> Patients may have a number of reasons for suboptimal adherence to prescribed topical therapy. They may not understand the disease or its consequences and fail to connect elevated IOP with potential loss of vision.<sup>5</sup> They may forget to take their medication or have difficulty administering eyedrops.<sup>5,6</sup> Cost of therapy or side effects may also be impacting adherence.<sup>5,7</sup>

**Poor adherence increases the risk of vision loss**

Simply put, many glaucoma patients do not believe they have a problem.<sup>2</sup> Because the early stages of the disease are often asymptomatic, patients may not notice loss of visual field until it's too late to do much about it. This makes poor adherence a risk factor for disease progression.<sup>5</sup> Lack of effectiveness of topical therapy due to poor adherence may prompt unnecessary therapeutic switching, additions, or even surgery, with its additional risks and costs.<sup>8</sup> This problem may be exacerbated by patients' reluctance to admit they are experiencing any difficulty with their therapy. Indeed, in one survey of 200 patients, 69% said they would not tell a doctor of their adherence problems even if asked.<sup>6</sup>

**Uncovering hidden barriers to therapy adherence: the i2i "4-step communication approach"**

A 4-step approach can help your patients understand that "ideal patients" are those who acknowledge when they are having trouble sticking with their regimen and proactively enlist your help to address problems with taking their medication.

1. Begin with a direct open-ended question — "Tell me how you've been taking your medication" — instead of a close-ended question like "Are you taking your medication?"
2. Reassure patients that you know almost everyone has some difficulty taking medication regularly, often for good reasons. Let patients know they will not be judged badly for sharing their problems with taking medication.
3. Explain to your patients the importance of providing you with accurate information about missed or forgotten doses so you don't change their therapy unnecessarily.
4. Then (and not before), ask about "forgetting" or "missing" medication(s). You could ask:
  - In the last week have you missed any doses of your medication(s)?
  - Did you take your medication(s) today?
  - How about a month ago?

**i2i: Conversations To Enhance Adherence**

i2i is a resource developed by physicians to optimize patient adherence to therapy through insightful physician-patient dialogue. This program features techniques that help identify and decrease patient barriers to adherence while motivating them to follow and maximize their daily glaucoma treatment regimen.

To find out more about i2i, please contact your **Pfizer Ophthalmics representative** or visit **i2iadherence.com**.

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# IU names Marshall vice president of diversity, equity, multicultural affairs

Indiana University (IU) President Michael A. McRobbie announced the appointment of Professor Edwin C. Marshall, O.D., MPH, as vice president of diversity, equity and multicultural affairs on July 18.

Dr. Marshall, a professor and associate dean for academic affairs and student administration at the IU School of Optometry, replaces Vice President Charlie Nelms, who has resigned to become Chancellor at North Carolina Central University in Durham.

In June, Dr. Marshall was

honored as the AOA's Optometrist of the Year.

"Ed Marshall is an extremely accomplished member of the faculty and a person who has established a truly national and international reputation for academic excellence in his profession," McRobbie said. "He also has a deep commitment to diversity and equity in higher education. He will have important responsibilities in his new role as vice president, and I am very pleased that he has agreed to take on this key assignment."

Dr. Marshall will have oversight for matters concerning diversity, equity and multicultural affairs on all IU campuses and more specific responsibilities at IU Bloomington. This will include relevant academic support services, K-12 outreach initiatives, student enrollment and retention initiatives and diversity and equity efforts.

Dr. Marshall has been an adviser to the medical faculty of the National University of Malaysia and the Cebu Doctors' College, College of

Optometry in the Philippines, and many other international accomplishments.

McRobbie also noted that Dr. Marshall's background in public health — he is an adjunct professor of public health at the IU School of Medicine — will enable him to play an important role in implementing IU's strategy for expanding life sciences research.

Dr. Marshall said he looks forward to working closely with McRobbie in shaping diversity and equity policies for the university.



Dr. Marshall

# ICO appoints Daum VP, dean for academic affairs



The Illinois College of Optometry President Arol Augsburger, O.D., announced the appointment of Kent Daum, O.D., Ph.D., as the vice president and dean for Academic Affairs of the Illinois College of Optometry (ICO).

Dr. Daum currently serves

as associate professor of optometry and associate scientist at the University of Alabama at Birmingham (UAB).

"Dr. Daum has a commitment to student recruitment, retention, and remediation and an appreciation for the value of faculty governance, defined educational standards, and assessment measures," said Dr. Augsburger. "He values clinically focused and evidence-based education as well as diversity and the importance of providing vision care to the indigent in society. He will bring to ICO a knowledge base of modern optometry and the

direction in which optometry and optometric education is moving."

Dr. Daum has extensive experience with accreditation preparation. He served as chair of UAB's curriculum committee, as a consultant to the Accreditation Council on Optometric Education and as chair of UAB's institutional self-study and review committee.

"Dr. Daum clearly has the credentials and the creative and enthusiastic spirit to be part of the successful future of the Illinois College of Optometry and the optometric educational field," said Dr. Augsburger.

## Campaign

from page 1

Childhood Computer Vision Syndrome, Ready for School Parent Quiz, Ready for School Word Search, and Understanding the Difference Between Vision Screenings and Vision Examinations.

"This is a 21st century problem," Nye said. "These kids are on the computer and video games so much they need to be taught visual hygiene, just as they learn personal hygiene. They need to learn to move away from the screen and to understand how the visual system interacts with computer displays."

Nye described the situation with many

people. "They dump in eye drops, presuming it's dry eye. Actually the problem is ergonomics, not just dry eye."

Dr. Press said in a typical home adults may have adjusted the monitor properly, at about 15 degrees below eye level, but "when a kid uses that computer, it's not comfortable."

In traveling with Dr. Press, Nye said he was surprised to learn of the link between poor vision and children's behavior. "I'm a well-educated scientist, and I was completely unaware of this link. It needs to be documented and people made aware."

## MOA celebrates 100th anniversary with AOA Low Vision University Program™

The Montana Optometric Association (MOA) recently celebrated its 100th anniversary as a professional organization in Helena. An excellent education program headed by Richard Newth, O.D. (Great Falls, MT); MOA President William J. Hasquet, O.D.; and MOA Executive Director Sue Weingartner featured distinguished speakers E. Robert Bertolli, O.D.; Robert Pannone, O.D.; AOA Trustee Ron Hopping, O.D., MPH; A. Paul Chous, O.D.; and Maynard Pohl, O.D.; and hosted the AOA LVRS Low Vision University™ program sponsored by Kemin Health.



Then-AOA LVRS Chair Tracy Williams, O.D., left, and Richard Newth, O.D.

This was the fourth Low Vision University™ educational program presented, with New Hampshire being the first stop of a 10-state program tour in 2007. AOA LVRS Council member, Mark Wilkinson, O.D., who presented with incoming Chair Bruce Rosenthal, O.D., in New Hampshire, heads Low Vision University™.

Then-AOA LVRS Chair Tracy Williams, O.D., provided a two-hour introduction to low vision rehabilitation at the well-attended MOA event. Drs. Newth and Williams were classmates at ICO and both are devoted to advancing optometry as a leader providing low vision care to the growing numbers of people with vision loss. Low Vision University™ has up to six hours of COPE-approved low vision education, which allows optometrists to learn more about low vision rehabilitation as a "treatment modality" and the impact of neutraceuticals.

Dr. Hopping noted at the MOA celebration banquet, "Montana continues to be a leadership state for the AOA."



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**Industry Profile**  
**is a regular feature**  
**in AOA News**  
**allowing**  
**participants of the**  
**Ophthalmic Council**  
**to express**  
**themselves on issues**  
**and products**  
**they consider**  
**important**  
**to the members of**  
**the AOA.**

## Industry Profile: Optos

Optos plc is a leading and rapidly growing medical technology company for the design, development, manufacturing and marketing of devices that image the retina.

Optos' platform technology is the Panoramic200 Scanning Laser Ophthalmoscope device—known as the P200. In a quarter of a second, the P200 device produces a high-resolution image of up to 200 degrees or approximately 82 percent of the retina in a single capture. The image—branded the optomap® Retinal Exam—provides eye care practitioners with clinically useful information that facilitates the early detection of disorders and diseases evidenced in the retina, such as glaucoma, diabetic retinopathy and age-related macular degeneration.

The Optos P200 device is placed in a practice's pretest area and networked into the doctors' examination lanes. The patient's optomap image is then captured in the pretest area and reviewed with them interactively in the lane with the doctor. This adds tremendous value to doctor-patient communication and brings the eye exam to life. The optomap Retinal Exam contributes greatly to enhanced clinical capabilities and adds tremendously to the patient's eye care experience.

Additionally, Optos' offers optomap® plus Medical Retinal Exam, a procedure for medically necessary disease management and follow-up. The optomap plus allows practitioners to document that a specific capture and review process has been followed and provides advanced annotation tools, such as measurement and ISNT Ratio measurement tools, for objective assessment and identification. This evidence can then be used to support reimbursement claims as required.

Optos recently introduced the latest version of its proprietary operating software—V2® Vantage. It is now available to all new partners and is currently being rolled out to the Optos customer base. The new software offers many new, innovative clinical advancements that will be beneficial to both the practitioner and patient. The new features include: 3D Wrap™ Patient Orientation Tool, ResMax™ High Resolution Enhancement for Central Pole, Practice Performance Statistics, Targeted Ophthalmoscopy Mode, and more.

"The introduction of V2 Vantage delivers on a key promise within our customer partnership agreements to keep our customers on the leading edge of retinal imaging technology," said Thomas W. Butts, chief executive officer, Optos plc. "We expect V2 Vantage to be particularly helpful to our customers in secondary care who are performing the optomap plus Medical Retinal Exam."

To promote the successful integration of the optomap Retinal exam into practices, Optos provides its customers with a wealth of technical, educational and marketing resources, including on-site staff and physician training, best practice protocols, patient education materials and marketing outreach programs, as well as continued maintenance and customer support.

As of Sept. 30, 2006, Optos had 232 employees serving more than 2,500 customers in the company's existing markets, currently the United States, Canada, the United Kingdom and Germany. Optos plc is headquartered in Dunfermline, Scotland, and was admitted to the Main Market of the London Stock Exchange on Feb. 15, 2006, trading under the symbol OPTS. The company's North American headquarters is based in Marlborough, MA.



**Esteemed ocular pharmacologist and textbook author, Siret Jaanus, Ph.D., announced her retirement at a reception hosted by Transitions Optical, Inc. during Optometry's Meeting™ in Boston. Transitions recognized Dr. Jaanus for her contributions to the industry and the advancement of healthy sight. Shown from left are Carole Bratteig, manager, education and training; Bette Zarat, vice president of Global Strategic Marketing for Transitions; Dr. Jaanus; and Denis Fisk, director of Global Education for Transitions.**

## Drug interaction info available on PDAs

**E**ye care professionals can now access Transitions Optical's medications database wherever they go.

Transitions announced its Ocular Side Effects Database tool, designed to raise awareness about the potential adverse ocular effects of medications, is available for download to a Personal Digital Assistant (PDA).

Downloadable from [www.transitions.com/medications](http://www.transitions.com/medications), the database provides easy access to information on medications that may pose a threat to healthy sight.

The database allows eye care professionals to quickly search for drugs by brand name to determine which medications may affect vision and gives details on how the quality and quantity of vision can be impacted by each drug.

"As the number of Americans taking prescription or over-the-counter medications continues to rise, it becomes increasingly important for eye care profession-

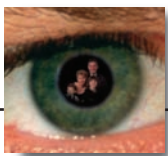
als to educate their patients on the possible ocular side effects—particularly since nearly 25 percent of patients don't tell their eye care professional what medications they're taking," said Carole Bratteig, manager, education and training, Transitions. "The downloadable version of the Ocular Side Effects Database will allow eye care professionals to quickly share these risks with patients, even when they don't have access to a computer."

The medications database complements the Transitions-sponsored clinical review paper, "Ocular Effects Associated with Medications," written by Siret D. Jaanus, Ph.D.

The paper provides eye care professionals with a reference guide of drugs and drug classes that may affect healthy sight.

To access the Ocular Side Effects Database or download it to a PDA, or to read the clinical review paper, visit [www.transitions.com/medications](http://www.transitions.com/medications).





### CL Council launches new Web site

The Contact Lens Council (CLC) launched a new Web site to educate people of all ages and vision needs about the wealth of new innovations currently available and how to be informed contact lens wearers.

Although more than 35 million Americans have made the choice to see the world through contact lenses, many are still unclear about the most current information, the importance of proper lens care and the full-range of lifestyle benefits that contacts now offer, according to the CLC.

To that end, the CLC, a non-profit organization and resource on vision correction, introduced its comprehensive Web site, [www.mycontactlenses.org](http://www.mycontactlenses.org).

"Consumers look to the Web for the latest news and

advancements, along with more in-depth information on their specific needs, such as contact lenses, lens care and related care guidelines," said Edward Schilling, executive director of the CLC.

"Through our new Web site, we hope to introduce the benefits of contact lenses to inexperienced consumers, aid in the journey for new and long-time users, as well as provide all consumers with useful information on safely wearing contact lenses and the importance of overall eye health."

Features of [www.mycontactlenses.org](http://www.mycontactlenses.org) range from frequently asked questions to a complete overview of contact lenses currently available. The following are just a few of the little-known facts featured on the site:

**Contact Lens History:** Contact lenses have been used for more than a century.

They once were made of glass and covered the entire front of the eye.

#### *Contact Lens Care*

**Section:** Contact lens care has been simplified to combine the three essential steps – cleaning, rinsing and disinfecting – into just one bottle of solution.

#### *What's New in Contact Lenses:*

Contact lenses are now being designed from "wavefront" laser beams that can make an exact topographical map of the front of the eye.

The CLC is a non-profit organization and educational resource on vision correction for consumers. Advisory members include the Contact Lens and Cornea Section of the AOA, Contact Lens Association of Ophthalmologists, and the Contact Lens Society of America.

### Transitions releases kid-focused education

Just in time for the start of the new school year, Transitions Optical introduced new kids-focused educational tools and resources for ODs to use to communicate the importance of healthy sight to younger patients and their parents.

The Healthy Sight Counseling for Children course series includes a COPE-approved module for optometrists and an ABO-accredited component for opticians.

The seminars focus on the Healthy Sight Counseling model of eye care and illustrate how this model can serve as a foundation to address the unique vision care and vision wear needs of children.

A short Skills Workshop for Real Life course is available for children to receive a quick, practical overview while in an optometrist's office.

"Healthy vision is criti-

cal to a child's early educational, functional and social development—and a child's eyes are more susceptible to certain risk factors that affect long-term ocular health, including impact and UV protection," said Denis Fisk, global director of education, Transitions. "These courses will encourage eye care professionals to take that extra step when making product recommendations for children by focusing on the full range of factors impacting a child's healthy sight and by taking the time to educate parents on what is required to optimize healthy sight now and preserve it for the future."

**Healthy Sight Counseling** promotes customized vision correction, maintenance and preventative eye care, and increased professional and patient awareness of eye health through education.

Aspects of healthy sight,

such as the need for UV and trauma protection and self and peer acceptance, are especially important for children.

The courses focus on providing both quality and quantity of vision and encourage optometrists to consider lens enhancements to address the individual needs of children.

The courses also highlight the importance of screening children for ocular disease and refractive error at an early age, stressing the need to consider various factors, such as systemic medications and their impact on healthy sight, when examining children.

For more information about the educational offerings, or to order a copy of the upcoming "Healthy Sight Counseling and Children" clinical review paper, contact a Transitions Optical Solutions Team representative or call (800) 848-1506.

### Hot new frames keep kids cool at school



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Shown are Barbie styles 335 and 336 by REM Eyewear



Shown is Converse style Fresh by REM Eyewear



Shown is Converse style Ambush by REM Eyewear





## MEETINGS

### August

2007 OCULAR DISEASE UPDATE  
Aug. 25-26, 2007  
Florida Optometric Assn.  
and AMO  
The Peabody, Orlando, FL  
Kellie@floridaeyes.org  
800/399-2334  
www.floridaeyes.org

Nova Southeastern University  
College of Optometry  
Glaucoma Update 2007  
Aug. 26, 2007  
NSU College of Optometry, Ft.  
Lauderdale, Florida  
Lorena Lizausaba  
954/262-4224  
oceaa@nsu.nova.edu  
http://optometry.nova.edu/ce/glau  
coma/index.html

AEA CRUISE SEMINAR – BALTIC  
HERITAGE  
Aug. 30-Sept. 9, 2007  
Star Princess  
888/638-6009  
aeacruises.aol.com

### September

THE ART & SCIENCE OF  
OPTOMETRIC CARE—A  
BEHAVIORAL PERSPECTIVE, 2007  
Sept. 6-10  
Grand Rapids, Michigan. Presented  
by OEP CLINICAL CURRICULUM.  
Contact: Theresa Krejci, 800/447-  
0370 or visit www.babousa.org

OPTOMETRIC EXTENSION  
PROGRAM  
FOUNDATION 38TH ANNUAL  
COLORADO VISION TRAINING  
CONFERENCE  
Sept. 7-9, 2007  
YMCA of the Rockies, Estes Park,  
Colorado  
George Hertneky, O.D.  
970/842-5166  
hertnekyg@mac.com.

FALL CONFERENCE  
VERMONT OPTOMETRIC  
ASSOCIATION  
Sept. 7-9, 2007  
Stoweflake Resort and Conference  
Center, Stowe, Vermont  
Lisa Martin Eriksson, O.D.  
802/434-4866  
Eriksson@gmavt.net

SOUTHERN COLLEGE OF  
OPTOMETRY  
SCO ALUMNI HOMECOMING  
AND CONTINUING EDUCATION  
WEEKEND  
Sept. 13-16, 2007  
Memphis, Tennessee  
Kristin Anderson, O.D.  
901/722-3356 or  
901/722-3234  
ce@sco.edu  
www.sco.edu

MAINE OPTOMETRIC  
ASSOCIATION  
SEPTEMBER “FALL” CONFERENCE  
Sept. 14-16, 2007, The Samoset  
Resort, Rockport, ME

Joann Gagne  
207/626-9920  
Moa.office@  
maineeyedoctors.com  
www.maineeyedoctors.com

PSS 2007: FORUM ON  
OPTOMETRY  
Sept. 14-16, 2007  
Mystic Marriott, Groton, Connecticut  
203/415-3087  
education@psseyecare.com  
www.psseyecare.com

MINNESOTA OPTOMETRIC  
ASSOCIATION FALL MEETING  
Sept. 21-22, 2007  
St. Cloud Civic Center, St. Cloud,  
Jessica E. Miller  
952/841-1122  
Jessica@mneyedocs.org  
www.minnesotaoptometrists.org

ILLINOIS OPTOMETRIC  
ASSOCIATION  
ANNUAL CONVENTION  
Sept. 27-30, 2007  
Itasca, IL Charlene Marsh  
800/933-7289 or  
217/525-8012  
ioabb@ioaweb.org  
www.ioaweb.org

NSU COLLEGE OF OPTOMETRY  
AND THE FLORIDA OPTOMETRIC  
ASSOCIATION  
2007 LEAGUES UNDER THE CE  
Sept. 27-30, 2007  
Atlantis Hotel and Casino, Paradise  
Island, Nassau, Bahamas  
Lorena Lizausaba  
954/262-4224  
oceaa@nsu.nova.edu  
http://optometry.nova.edu/ce/leag  
ues/index.html

KOA FALL CONFERENCE  
KENTUCKY OPTOMETRIC  
ASSOCIATION  
Sept. 28-30, 2007  
Radisson Hotel, Covington, Kentucky  
sarah@kyeyes.org

VIRGINIA OPTOMETRIC  
ASSOCIATION  
2007 FALL CONFERENCE  
Sept. 29-30, 2007  
Ritz-Carlton Hotel, Tysons Corner, VA  
Bruce B. Keeney, Sr.  
804/643-0309  
voaeyedocs@aol.com  
www.voaeyedocs.org

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Sept. 30, 2007  
Holiday Inn-Plainview Long Island,  
Plainview, NY  
Janet Swartz  
978/470-3500 or 877-825-2020  
FAX: 978/470-4520  
nepc@comcast.net  
www.neconferences.com

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aeacruises.aol.com  
optometriccruiseseminars.com

### October

IOA FALL SEMINAR  
INDIANA OPTOMETRIC  
ASSOCIATION  
Oct. 3-4, 2007  
Whittenberger Auditorium,  
Bloomington, Indiana  
www.ioa.org

VISION EXPO WEST  
Oct. 4-6, 2007  
Las Vegas, NV  
www.visionexpowest.com

EAST/WEST EYE CONFERENCE  
Oct. 4-7, 2007  
Cleveland, OH  
www.eastwesteye.org

MISSOURI OPTOMETRIC  
ASSOCIATION  
ANNUAL CONVENTION  
Oct. 4-7, 2007  
Ritz-Carlton, St. Louis, Missouri  
Joyce Baker  
573/635-6151  
www.moeyecare.org

CHILDREN’S VISION AND  
LEARNING CONFERENCE  
Wichita Airport Hilton, Wichita,  
Oct. 5, 2007

KANSAS OPTOMETRIC  
ASSOCIATION  
FALL EYECARE CONFERENCE  
Oct. 5-7, 2007  
Airport Hilton, Wichita, KS  
info@kansasoptometric.org  
www.kansasoptometric.org

FALL OPTOMETRIC EDUCATION  
CONFERENCE  
GEORGIA OPTOMETRIC  
ASSOCIATION  
Oct. 6-8, 2007  
University of Georgia, Athens,  
Georgia  
800/949-0060  
www.goaeyes.com

NEW ENGLAND PROFESSIONAL  
CONFERENCES  
NATIONAL GLAUCOMA SOCIETY  
REGIONAL MEETING  
Oct. 7, 2007  
Desmond Hotel and Conference  
Center, Malvern, Pennsylvania  
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Oct. 10-11, 2007

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Oct. 11-14, 2007  
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DoubleTree Lloyd Center, Portland,  
Oregon  
Martin L. Wangen, CAE  
406/443-1160  
FAX: 406/443-4614  
mwangen@rmsmanagement.com  
www.gwco.org

HUDSON VALLEY OPTOMETRIC  
SOCIETY FALL SEMINAR  
HUDSON VALLEY OPTOMETRIC  
SOCIETY  
Oct. 12, 2007  
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Dr. Daniel Lack  
845/336-6124  
dlack@hvc.rr.com

OKLAHOMA ASSOCIATION OF  
OPTOMETRIC PHYSICIANS  
PIONEERS IN OPTOMETRY  
REGIONAL CONFERENCE  
Oct. 13-15, 2006  
Renaissance Hotel, Tulsa, OK  
www.pioneersinoptometry.com

NEBRASKA OPTOMETRIC  
ASSOCIATION FALL  
CONVENTION  
Oct. 19-21, 2007  
Holiday Inn, Kearney, NE  
Kathi Schildt  
402/474-7716  
noa@assocoffice.net

NEW ENGLAND PROFESSIONAL  
CONFERENCES  
NATIONAL CORNEA AND  
ANTERIOR SEGMENT SOCIETY  
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Oct. 14, 2007  
Holiday Inn, Marlborough,  
Massachusetts  
Janet Swartz  
978/470-3500 or  
877/825-2020  
nepc@comcast.net  
www.neconferences.com

COVD 37TH ANNUAL MEETING  
www.covd.org.  
Renaissance Vinoy Resort and Golf  
Club, St. Petersburg, FL  
Oct. 16 - Oct. 20, 2007  
Jackie Cencer  
888/268-3770  
330/995-0718  
jcencer@covd.org

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UNIVERSITY COLLEGE OF  
OPTOMETRY  
INTERDISCIPLINARY  
MANAGEMENT OF THE DIABETES  
PATIENT  
Oct. 20-21, 2007  
Ft. Lauderdale, Florida  
Lorena Lizausaba  
954/262-4224  
oceaa@nsu.nova.edu  
http://optometry.nova.edu/ce/dia  
betes/index.html

AMERICAN ACADEMY OF  
OPTOMETRY  
Oct. 24-27, 2007  
Tampa, FL  
www.aaopt.org

OPTOMETRY ASSOCIATION OF  
LOUISIANA  
FALL GUMBO CE  
Oct. 27, 2007  
Holiday Inn Convention Center,  
Alexandria, Louisiana  
Dr. Jim Sandefur  
318/335-0675  
FAX: 318/335-0677  
optla@bellsouth.net  
www.optla.org

### November

ARKANSAS OPTOMETRIC  
ASSOCIATION ARKANSAS FALL  
MEETING  
November 1-4, 2007 Rogers, AR  
Vicki Farmer  
501.661.7675  
Fax: 501.372.0233  
aropt@swbell.net  
Vicki@arkansasoptometric.org

NEW ENGLAND PROFESSIONAL  
CONFERENCES  
NATIONAL GLAUCOMA SOCIETY  
REGIONAL MEETING  
Nov. 4, 2007  
Highlander Hotel, Manchester, New  
Hampshire  
Janet Swartz  
978/470-3500 or 877/825-  
2020  
FAX: 978/470-4520  
nepc@comcast.net  
www.neconferences.com

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CONFERENCE  
UM-St. Louis College of Optometry  
Nov. 7 and Dec. 5, 2007  
314/516-5655  
www.umsl.edu/~conted/bvlC

WEST VIRGINIA OPTOMETRIC  
ASSOCIATION  
WVOA ANNUAL CONVENTION  
November 8-11, 2007  
Charleston Marriott Hotel,  
Charleston, West Virginia  
Roger K. Price  
304/345-4710  
wvoa@wvoa.com  
www.wvoa.com

CALIFORNIA OPTOMETRIC  
ASSOCIATION  
MONTEREY SYMPOSIUM 2007  
Nov. 16-18, 2007  
Monterey Conference Center and  
Monterey Marriott in Monterey, CA  
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author of *Diabetic Eye Disease:  
Lessons from a Diabetic Eye Doctor*

### FOR MORE INFORMATION:

Lorena Lizausaba, Coordinator  
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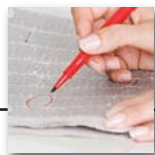


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Mark Myers and Andrew Gurwood: Pharmaceutical Update, Ocular Blunt Trauma, Periocular Malignancies  
John Lahr and Paul Karpecki: Ocular Surface Disease, Grand Rounds  
Ian Lane: Electronic Patient Record

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San Miguel Plaza Hotel: (787)- 300- 4000 [www.sanmiguelplazahotel.com](http://www.sanmiguelplazahotel.com)

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American Optometric Association

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**Panama Canal**, 2/25/08-3/6/08, *Coral Princess*®. Ft. Lauderdale, Aruba, Cartagena, Panama Canal, Costa Rica, Ocho Rios, Ft. Lauderdale. Cruise fares from \$1499.

**Greek Isles**, 6/5/08-6/17/08, *Emerald Princess*®. Venice, Dubrovnik, Corfu, Katakolon, Athens, Mykonos, Kusadasi, Rhodes, Santorini, Naples/Capri, Rome(Civitavecchia). Cruise fares from \$1245. **Speaker: Dr. Harue Marsden**

**Alaska**, 6/29/08-7/6/08, *Star Princess*®. Seattle, Ketchikan, Tracy Arm Fjord, Juneau, Skagway, Victoria, Seattle. Cruise fares from \$1049. **\*\*\*Follows the AOA Congress in Seattle 6/25-6/29/08\*\*\* ~July 4<sup>th</sup>!~**  
**Speaker: Dr Louise Sclafani.**

**British Isles**, 7/1/08-7/13/08, *Grand Princess*®. London (Southampton), Guernsey, Cork, Dublin, Liverpool, Belfast, Glasgow, Inverness/Loch Ness, Edinburgh, Paris/Normandy, London (Southampton). Cruise fares from \$1207.  
**Speaker: Dr. Robert Wooldridge.**

**Holy Land**, 11/4/08-11/16/08, *Pacific Princess*®. Rome (Civitavecchia), Sorrento/Capri, Alexandria, Port Said, Jerusalem, Galilee/Nazareth, Kusadasi, Patmos, Santorini, Athens. Cruise fares from \$2890 (oceanview).

**Eastern Caribbean**, 1/25/09-2/1/09, *Crown Princess*®. Ft. Lauderdale, Princess Cays, St. Maarten, St. Thomas, Grand Turk, Ft. Lauderdale. Cruise fares from \$659.

**Classic Southern Caribbean**, 2/15/09-2/22/09, *Caribbean Princess*®. San Juan, Barbados, St. Lucia, Antigua, Tortola, St. Thomas, San Juan. Cruise fares from \$909. **\*\*President's Day\*\***

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## Great Western Council of Optometry

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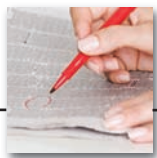
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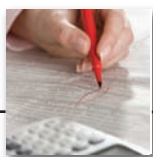
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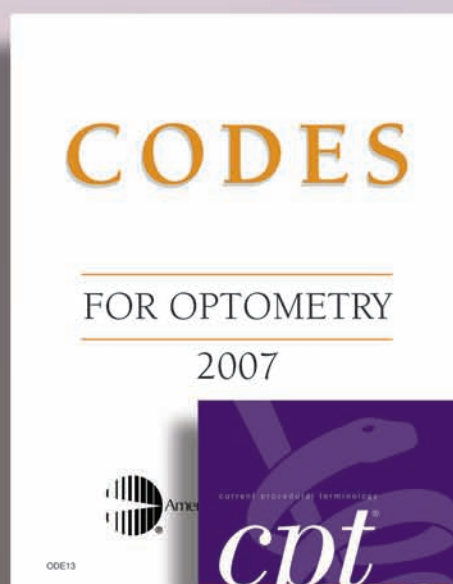


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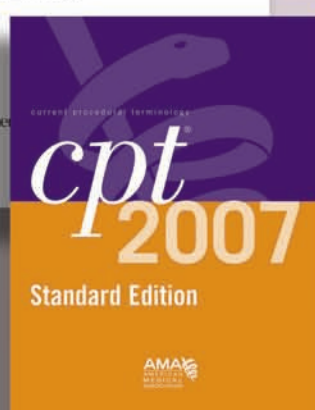
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